THE ROLE OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS IN THE ASSESSMENT OF QUALITY*

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THE modification of the Social Security Act creating Professional Standards Review Organizations (PSROs) was enacted more than two years ago. In looking at its accomplishments, its problems, and its directions one is tempted to compare it with a child of the same age. Two-year-old children are apt to be noisy, messy, and obviously dependent; being newly injected into the family, they may modify the habits of the parents into new patterns. It is difficult to describe the accomplishments of a two-year-old child except in terms of other two-year-old children. The problems are usually obvious and the future directions for most hold bright promise—at least in the opinions of the parents.

The legislative act creating PSROs is long, detailed, and complex. One might question whether this a good form of legislation for an essentially untested innovation. To many it would have seemed more appropriate to have been firm in principle and mandate but to have been much more flexible as to the process of quality assessment. However, we have a specific mandate and are proceeding under it.

First, it would seem useful to review the history of this mandate, at least superficially, in order to clarify the intent. This act was passed in 1972. As recently as 1962 the passage of such legislation was unthinkable, and no such project was even introduced into the Congress of the United States or into any state legislature. Was this because the quality of medical care was not in need of review as to quality at any time in the preceding decades? Most of our quality controls in health have

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been introduced in response to abuse. Medical licensure by the states came about a century ago because the public recognized that a diploma from a school of medicine could readily be an empty credential. The schools of medicine themselves became subject to review somewhat later for this very reason. The American College of Surgeons started the accreditation of hospitals in response to gross shortcomings, and certification by specialty boards was necessitated because of nonmeritorious self-designation. These various structural criteria of quality were publicly recognized as being both necessary and appropriate.

Although the title of this conference is *The Professional Responsibility for the Quality of Health Care*, the motivation for the legislative act of 1972 appears to have a significant part of its origin in another concern. The Medicare and Medicaid law became operative in 1966. A large body of rule-making was promulgated and continues to be promulgated. There are conditions of participation, methods of reimbursement, and the voluminously detailed setting of standards; also embodied in the law was utilization review. The cost overruns of Medicare and Medicaid were alarming and had profound fiscal implications for the entire government of the United States. This was perceived quickly in the Congress and in 1969 it had led the president to declare a "health crisis." The staff of congressional committees made some direct investigations of complaints received by the Congress and found some gross abuse. One can easily recognize that the abuse was small in proportion to the size of the program, but one can also easily understand the congressional staff's response to the discovery of abuse in a program whose costs were so vastly in excess of prediction. On any topic of controversy, the Congress constantly receives spontaneous advice from interested persons; the cost overruns of Medicare and Medicaid were no exception. One of the ultimate results of this advice was the Health Maintenance Organization Act of 1973. Another result is the present PSRO legislation which was passed after the claims for peer review in both cost control and quality assurance had been heard.

The advice, of course, came from the medical profession. It was taken up by what is called "organized medicine" as a form of professional self-discipline. But under the heading of problems—which it seems inappropriate to detail here—may be listed the vacillating, and at times hostile, attitude of organized medicine to the PSRO Act and its implementation. Not until June 1974 did the organized profession take

a resigned and even conciliatory attitude to the implementation of the act. This is not to say that throughout the entire period there were not elements of organized medicine which were most helpful and expert, but these were by no means consistently in the majority.

It is interesting to look at the expressed purpose of the act. The medical profession constantly expresses the concept that the whole purpose of the act is to improve the quality of medical care. One frequently sees the adjective "highest" in front of the word "quality." This conference is about quality. However, the stated purpose of the act is "To promote effective, efficient, and economical delivery of health services of proper quality for which payment may be made under the Act." The test says nothing about the highest quality; such terms as efficient, economical, and payment seem to reveal equal concern with cost. It is cost and the excessive costs of Medicare and Medicaid that made the act possible in 1972, whereas it was unthinkable in 1962 when the federal government was not responsible for the direct payment of health services. This dichotomy between concern for the cost of care and for the quality of care creates much of the present dilemma in PSRO policy. While there are various criticisms with the manner in which the act has been implemented and the speed with which this has been done, all in all, considering the then-extant attitude of the medical profession, the endeavor has been impressive.

The National Professional Standards Review Council was chosen in the late spring of 1973 and began its meetings that summer. Area designations were promulgated in a little more than six months; guidelines for such organizations appeared within less than a year. I shall not go into the controversy as to why only guidelines have been forthcoming, rather than rules and regulations. Suffice it to say that the untested experimental nature of the methodology is the chief reason. By the summer of 1974, 11 conditional PSROs and 91 planning PSROs were under contract. Contracts had been let for many other implementing features, including a $1 million contract with the American Medical Association to develop model criteria.

There have been all sorts of problems, but presently the main problem is associated with the fundamental disagreement as to the purpose of the act. Congress has not seen fit to appropriate an adequate sum for the ensuing year to do more than partially implement the act. If the funds had been appropriated fully, it was intended 1) to convert many

of the 91 planning PSROs to conditional PSROs if they had this capability and 2) to establish planning PSROs in as many of the 203 designated areas as wish to apply, so that by January 1976 most of the United States would be involved in PSRO activity, as was intended by the original legislation. Apparently the funds that were appropriated were deliberately calculated to be insufficient for this goal. The true intent of Congress can only be surmised; some would see it as an attempt to ascertain what a few PSROs will accomplish before national implementation, despite the original Congressional mandate to apply the system to the entire nation.

Further, in the same act in which it created the PSRO mechanism, the Congress mandated a new and much stronger form of utilization review. The implementation of this new utilization review has been delayed until now in an attempt to resolve what appeared to be differences between these two processes. It is clear that the entire nation will not have PSROs, hence control of costs must be approached by the utilization review (UR) mechanism in the interval. But the UR mechanism has now been made compatible with the PSRO Act, so that it in fact represents the in-hospital delegated function of the PSRO. There has been much controversy about this and one can take either a pessimistic or optimistic view of Congressional duplicity or duplication. I am an optimist or I would not be involved. In many areas of the United States the new UR regulations may speed implementation of the PSRO process. In addition to the process of Congressional appropriations as a form of policy making, there have been two legislative soundings. Public Law 92-222 contains, almost as an appendix, a charge and a $10 million authorization for a major investigation of the whole methodology of quality assessment. This has not yet been undertaken, but if it were it might produce constructive direction. Certainly Public Law 93-641, the Comprehensive Health Planning and Development Act signed on January 4, 1975, has indirect bearing, by a very different process, on the over-all subject of quality assessment.

We have only begun a long journey in this field, but we have begun. As the conditions of the future incorporate the concept of essentially universal entitlement to necessary health services, probably through an incremental form of national health insurance, I predict that the interrelated concerns of quality, cost, availability, and access will produce broad participation in forging new legislation to accomplish these

goals concomitantly. We shall undoubtedly look back upon the present period as a very crude one. We shall see that after having adopted structural criteria for health services earlier in the century and having adopted process criteria with the PSRO Act we shall have remained confused and unsatisfied as to our health services: many other values such as outcome, access, satisfaction of defined populations, and equity remain to be evolved. But, as stated above, the present legislation is far too constrictive and detailed in methodology to produce the desired results. Before the present Act can be modified legislatively it will have to demonstrate something either to the Congress or to the profession; let us hope it will be both. As an optimist I shall conclude by citing the Chinese adage: "The first step is half the journey."